

MediOAK Compounding Pharmacy - COMPOUND PRESCRIPTION



Phone: 281-980-9979 | Fax: 281-993-5129

Ways to Place an Order

1. Fax this prescription form to 281-993-5129
2. Email this prescription form to info@medioakpharmacy.com
3. Send an e-prescription through our portal

Note: Verbal orders are not accepted.

You must use one of the above methods to send your prescriptions.

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
DOB: ____ / ____ / ____ Phone: () _____ - _____
Allergies: _____

Weight Management

X	Medication	Strength	Directions	Quantity	Refills
	Semaglutide INJ	0.25mg/0.5ml	0.25 mg qWK	2ml	
	Semaglutide INJ	0.5mg/0.5ml	0.5 mg qWK	2ml	
	Semaglutide INJ	1mg/0.75ml	1.0 mg qWK	3ml	
	Semaglutide INJ	1.7mg/0.75ml	1.7 mg qWK	3ml	
	Semaglutide INJ	2mg/0.75ml	2.0 mg qWK	3ml	
	Lipotropic B12 INJ (methionine, inositol, choline, methylcobalamin)	15mg/50mg/25mg/1mg per mL	INJ 1-3mL IM 1-3 qWK	<input type="checkbox"/> 3 x10mL <input type="checkbox"/> 10mL	<input type="checkbox"/> _____ <input type="checkbox"/> PRN <input type="checkbox"/> none
	Triple Amino Boost Capsules (L-leucine, L-lysine, L-arginine)	200mg/100mg/100mg	<input type="checkbox"/> Take 1 CAP PO QD <input type="checkbox"/> Take 1 CAP PO BID	<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90	<input type="checkbox"/> _____ <input type="checkbox"/> PRN <input type="checkbox"/> none
	Phentermine/Topiramate Capsules	<input type="checkbox"/> 4.5mg/23mg <input type="checkbox"/> 9mg/23mg <input type="checkbox"/> 13mg/23mg <input type="checkbox"/> 16.5mg/23mg <input type="checkbox"/> 4.5mg/46mg <input type="checkbox"/> 9mg/46mg <input type="checkbox"/> 13mg/46mg <input type="checkbox"/> 37.5mg/46mg	<input type="checkbox"/> take 1 CAP PO qAM <input type="checkbox"/> take 1 CAP PO qAM for 14 days, then 2 CAP PO qAM <input type="checkbox"/> take 2 CAP PO qAM	<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90	<input type="checkbox"/> _____ <input type="checkbox"/> PRN <input type="checkbox"/> none
	Bupropion / Naltrexone SR Capsules	90mg/10mg	<input type="checkbox"/> week 1: 1 CAP PO qAM, week 2: 1 CAP PO qAM, 1 CAP PO qPM, week 3: 2 CAP PO qAM, 1 CAP PO qPM, week 4: 2 CAP PO qAM, 2 CAP PO qPM <input type="checkbox"/> 2 CAP PO qAM, 2 CAP PO qPM	<input type="checkbox"/> 70 <input type="checkbox"/> 90 <input type="checkbox"/> 12	<input type="checkbox"/> _____ <input type="checkbox"/> PRN <input type="checkbox"/> none

notes: _____

Prescriber Information

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

License #: _____ NPI #: _____

Signature: _____ Date: _____